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Health For All Now!

People's Health Movement Report to People's Health Assembly (PHA-4), 2018 and Alternate Civil Society Declaration on Primary Health Care (PHC)

People's Health Movement (PHM)

People's Health Movement Report to People's Health Assembly 4, 2018

and

Alternate Civil Society Declaration on Primary Health Care (PHC)

People's Health Movement (PHM)

Health For All Now!

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People's Health Movement Report to People's Health Assembly 4, 2018

About PHM and PHM Objectives

The People's Health Movement (PHM) is a global network bringing together grassroots health activists, public interest civil society organisations (PICSOs), researchers and academic institutions from around the world, particularly from low and middle income countries (L&MIC). Since its inception in 2000, PHM has played an increasing and significant role in global health: increasing capacity of community activists to participate in global health; monitoring global health policies and governance; and providing publication and a platform for engagement, advocacy and action around health for all. Much of this work has been carried out on a limited budget, with a small secretariat, and drawing significantly on volunteers. By 2018 PHM had a presence in almost 80 countries, ranging from a large network with more than 200 affiliated organisations in India, through medium-sized groups in Central and South America, South Africa and South and East Asia, and a growing and active European region, to small collections of activists in several countries on all continents.

PHM's vision is: "Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives...."

The objectives of PHM are:

- To promote Health for All through an equitable, participatory and inter-sectoral movement and as a Rights Issue.
- To advocate for government and other health agencies to ensure universal access to quality health care, education and social services according to people's needs and not their ability to pay.
- To promote the participation of people and people's organisations in the formulation, implementation and evaluation of all health and social policies and programmes.
- To promote health along with equity and sustainable development as top priorities in local, national and international policymaking.
- To encourage people to develop their own solutions to local health problems.
- To hold local authorities, national governments, international organisations and corporations accountable.

The People's Charter for Health is the framework within which PHM acts and offers strategic guidance to the movement. It is both a tool for advocacy and a framework for action, guiding which statements we sign onto and our campaigns and activities.

PHM is a network of networks, organisations and individuals with some centrally supported programs. As a movement PHM is fairly loosely structured with country circles which come together for joint action around specific issues, with most being informally structured but with a few countries having formed legal entities and raised funds. Regionally, PHM aims to build coalitions and networks to encourage support,

sharing and learning, and to offer a platform for organising and advocacy on regional and global health governance, building solidarity and action around issues specific to the region.

Globally, regionally and in countries PHM can be seen as a) a platform for analysis, campaigning, mobilising, advocacy and resistance b) as a network builder, building solidarity and collaboration and c) as a bridge between the local and the global.

We have a number of centrally supported programmes, namely: the International People's Health University (IPHU), Global Health Watch (an alternative world health report); Global Health Governance (currently takes the form of watching and critical support of WHO), the Health for All campaign and the People's Health Assembly (PHA), held approximately every 5 / 6 years. The last PHA was held in Cape Town in 2012, and this report provides an overview of PHM activities from 2012 to the next PHA in Bangladesh, November 2018.

The main governing body of PHM is the Global Steering Council (SC), formed of a representative from each region, each global programme, affiliated networks, and the Advisory Council. Every 3 years, during the governance renewal process of PHM, some SC members step down to allow space for younger health activists who have demonstrated commitment and capacity within their region and globally. A principle of rotation is built into PHM's governance structure, recognising a need for both continuity and change. Each committee functions for 3 years, and no person is on a committee for more than two terms. Representation rotates between different active countries in a region and within networks. Our current Council sits till January 2019, so there will be renewal processes taking place in some regions in 2018.

PHM has in the last few years been challenged in raising resources, in particular core resources.

We have been working on expanding our donor base, as well as looking at ways to ease financial needs through seeking non-financial donations. Despite financial restrictions, we have continued to grow and maintained core activities. Donors and organisations that have supported PHM in the past few years, either financially or through non-financial support, include: Medico International, the International Development Research Centre (IDRC), Open Society Foundation, Medecine Pour le Tiers Monde (M3M), Medicine du Monde, WEMOS, Health Poverty Action, Global Justice Now, FOS, Medicos del Mundo and other organisations, service providers and individuals.

Regional highlights

Regions that have strengthened over the period have included West Africa, where we previously had a very small presence, Southern and East Africa, in particular South Africa, and Europe.

Southern and Eastern Africa:

Countries in this region with some activity include South Africa, Zimbabwe, Uganda, Tanzania, Kenya, Zambia and Djibouti. Key issues being dealt with by a number of countries in the

region are: national health insurance systems and human resources for health, including CHWs. Activities and campaigns in the region have included an increasing emphasis on Universal Health Coverage (UHC); monitoring implementation of ESCR, National Health Insurance schemes and participation in April 7th activities (World Health Day). Highlights from countries include: PHM South Africa has conducted research for the civil society engagement for health for all project, has run a number of "South African People's Health University" or SAPHU, and is part of a coalition organizing around a "People's National Health Insurance". The circle is actively involved in supporting community health committees, and in writing media pieces and lobbying provincial and national government on key health issues. There is some collaboration between countries around specific issues, in particular national health insurance; and Tanzanian and South African activists participated in the WHO Watch programme. PHM Kenya has formed a new secretariat and recently held a strategic planning meeting, and Zambia has put effort into revitalizing the country circle; there is growing interest and action in reviving PHM Malawi. South Africa and Tanzania have secured funding for certain activities.

West Africa:

In West Africa PHM has a presence in 18 countries of which 5 are active, namely Ghana, Benin, DRC, Guinea, Gabon. Campaign issues in PHM circles in the region have included human rights, UHC, anti-tobacco, AIDS accountability scorecard assessment (PHM Ghana, together with other organisations); conducting research for the civil society engagement for health for all project (PHM in the DRC); PHM Ghana has participated in WHO Watch at a global level a number of times and have been one of the country circles to take WHO Watch activities to the country level – in 2017 they organized a civil

society workshop on the WHO agenda for the WHA 2017 looking at Ghana's perspective, and submitted a position paper to the minister of health and the lead delegate of Ghana's team to WHO. Activities in this region have included advocacy, issuing statements, press releases, capacity building, mapping of partners (tobacco control in Gabon), organizing workshops around specific issues and attending workshops and conferences.

Latin America:

In PHM LA, challenges remain in communication and language differences within the region, and with the voluntary nature of PHM, given work commitments. There has been a reduction in funding to the region and many civil society organisations associated with PHM have closed as a result. Recent developments in the region include: strengthened relationship with Primary Care Physicians in Argentina with involvement in their Congresses;more active involvement in and collaboration with ALAMES. Highlights from the region include: holding a number of IPHU (UISP) as part of the development of activists in the Ministry of Health of El Salvador and in the National Health Forum, and involving persons from other countries and regions. In Brazil and Colombia, the civil society engagement for health for all research was an opportunity to strengthen PHM actions and the network of

organizations involved. Key issues/ campaigns in the region include: food sovereignty, nutrition, seed sharing fairs, mobilising against extractive industries and against privatization of health / health services; interactive mapping; defence of territories and water, including indigenous lands; Buen vivir; right to water; agro-ecology, social participation in health, and defence of the SUS (Brazilian National Health System); marches as part of the campaign for LGBTI rights, against femicide and violence against women and children, against racism and for the right to health of black women.

PHM North America:

Challenges include vast geographical distances and lack of an organizational home for PHM Canada. PHM US has hosted a few in country People's Health Universities and organised sessions around the World Social Forum. Activities include issuing of statements (countries and regional), initiation of reproductive justice caucus; PHM US engagement with April 7 activities and PHM Canada engagement with SaskForward austerity and health report. The regional focus has been on extractive industries and trade and health.

Middle East and North Africa (MENA):

The political situation characterized by war in Iraq, Syria and Yemen and the continued occupation of Palestine has limited PHM activities. Despite this, there has been some progress in the region: there are currently seven active countries in the MENA region: Egypt, Jordan, Morocco, Lebanon, Palestine, Tunisia and Yemen. The regional PHM/WHO conference in Tunis (17-20/11/2017) was used as an opportunity to reinvigorate PHM in the region, and this was further consolidated during the IPHU held in Jordan in 2018. Some core activities included the health insurance law (Egypt, Palestine), the right to health (Tunisia, Morocco, Lebanon), rational use of medicine and access to medicines (Palestine, Morocco, Lebanon). Palestine PHM activists have undertaken training using the "building a movement for health" tool and have had a focus on young people and have also included a focus on mental health. Campaigns took place in Morocco and Tunisia to defend public health care facilities against privatization and neoliberal policies. Countries participating in the Tunis conference have asserted their commitment to support UHC and right to health initiatives in the region.

Europe:

The region has 11 countries with an active PHM group (Italy, Spain, Greece, France, Belgium, Germany, Norway, Sweden, UK, Turkey, Croatia); and 4 countries with individual contacts. Coordination takes place through online Skype meetings every month, with responsibility being rotated between different countries. Highlights of recent activities in 2017 include: a Europe PHM meeting took place in Turkey in June 2017; PHM Europe participated in (and coordinated activities) of the April 7 campaign on World Health Day- 6 countries in Europe had activities related to the April 7 campaign, participated in activities around G7 health, participated in WHO Watch, organised a summer school on healthcare commercialisation (July 2017) and participated and assisted in coordinating several conferences. Italy participated in the research for Civil Society Engagement for Health for all. Europe has strategically used meetings taking place to meet as PHM Europe, for example the IAHPE conference in Thessaloniki in September 2017 and the G7 mobilisation. The main campaign in PHM Europe is organised around 7 April as people's health day, focused on opposing health commercialisation and particularly healthcare privatization; there is also activity around the situation in Turkey and building solidarity with

Academics for Peace, in collaboration with IAHPE aiming to widen and strengthen the solidarity campaign to include PHM globally with a working group being created to support this effort. In several countries there are groups and people active on migrants' and refugees' health and rights.

JSA / PHM India:

There have been many activities falling within the areas of a) strengthening the public sector (advocating for policy level interventions for Right to Health and Health Care, demanding Primary Health Care and health systems to provide accessible health care services for the poor and marginalized, and working towards improving Community Health Worker Programmes and Community Based Monitoring of health services); b) Women's health rights and gender equity (voice the needs and requirements of the grassroots at the national forum through participation of multi-level stakeholders across multiple states); c) Access to medicines and equipment and rational use of medicines (exploring provision of free drugs through public facilities, intellectual property rights and Pharmaceuticals policy and other related topics); d) analysing and campaigning against privatization and public-private partnerships; e) analysing the changing political, social, economic and environmental determinants of health, and f) campaigning on other issues as they arise. Activities include policy intervention; developing and releasing statements and memoranda; writing articles; attending and organizing conventions, raising critical debates and organizing discussions; budget interventions; advocacy; campaigns including participating in the April 7 campaign; writing open letters; facility surveys; organizing workshops.

South East Asia, Australia and Asia Pacific:

PHM in this region currently has a presence in: Thailand, Malaysia, Cambodia, South Korea, Indonesia, Vietnam, Philippines and Australia. In 2017 the regional coordinator visited South Korea PHM, which has fairly recently become active. Philippines has an active country circle with activities on various issues including: Human Rights issues (pressing the current president to stop the extra-judicial killings, including of health workers); anti-privatisation campaign; holding 7th of April rallies; raising issues of indigenous people; etc. PHM Philippines has had two IPHU's, one in October 2013 and in 2017, a 3-day International People's Health University on "Public Information and Advocacy Skills Training - Towards Strengthening the People's Health Movement-Philippines". PHM Australia is working with a coalition of organisations to lobby for reinvestment in PHC and Health Promotion, continued advocacy about TNC's, advocacy on trade and health.

South Asia:

Active countries are Nepal, Bangladesh, Pakistan and Sri Lanka. PHM Nepal: A student circle has regular discussion forums on different public health issues where there is networking with students and teachers from different fields. PHM

Pakistan is attempting to influence the policy making processes to align with the PHM charter; there have been efforts to grow PHM and there are now over 150 grassroots organisations affiliated to PHM Pakistan; an advocacy project has been launched on the allocation of budgets to Nutrition and Health, lobbying parliamentarians to include health rights as basic rights in the constitution and implementation of Infant Feeding Formula legislation; advocacy and awareness on nutrition in remote areas. More than 70 media persons were sensitised on malnutrition. PHM Sri Lanka hosts regular meetings and has been lobbying government to stop privatisation and to ensure implementation of the Drugs policy, and, in addition, working on occupational health issues.

PHM Bangladesh:

A number of activities are / have been implemented including: a workshop on Sustainable Development Goal 3 (SDG-3) and a meeting on Urban Health Systems; PHM members visited Rohingya camps to understand the situation especially public health and human rights and organized a round table at Reporters Unity to share their observations; PHM Bangladesh held their annual general meeting in January 2018 with 145 Members present. Members committed to host the People's Health Assembly-4 in Bangladesh in 2018 and established a secretariat for PHA-4 from a number of organisations. PHM Bangladesh has reviewed the proposed Health Welfare Law 2015 and identified areas for improvement and made recommendations accordingly; it has also reviewed the Curriculum of Nursing education and eligibility of students, the effectiveness of community clinics and campaigned against Pathology & ICU businesses along with overmedication

Global Programmes

Global Health Watch 5

Production of Global Health Watch (GHW) 4 was completed in 2015 and GHW5 was completed in 2017. GHW continues to have a major utility as a resource for issues around global health, with a committed readership that includes academia, activists' organisations and policy makers. Several public health schools regularly use material in the Watch as resource material.

GHW was published by Zed books, and we increased the number of pre-paid copies from 1,000 to 1,500. Launches of GHW 4 and 5 were held in many countries around the world.

The contents of GHW 5 have continued to be structured around five sections: 1) Economic and Political Architecture of the Globe 2) Contemporary issues and debates on Health Systems; 3) Beyond Health Care – the Social Determinants of Health; 4) 'Watching' important institutions and processes; 5) Stories of Actions,

Struggles and Change.GHW5 was structured around the broad theme of 'Global Governance for Health in the context of SDGs'.

An Editorial Board oversees the development of content and a group of Civil Society Organisations forms the **co-ordinating group**: this includes People's Health Movement, Medact, Third World Network, Health Poverty Action, Medico International, Asociación Latinoamericana de Medicina Social (ALAMES).

The editorial group and the co-ordinating group function closely to develop the contents. The Secretariat was located at the People's Health Movement's Secretariat office in New Delhi, India.

Watching the World Health Organization

The WHO Watch Program is designed to promote and advocate for democratic Global Governance for Health. The program incorporates elements of resource development, advocacy and capacity building of young activists and activity is designed to closely monitor the WHO's Executive Board (EB) meeting in January and the World Health Assembly (WHA) in May. It is also used as an opportunity to intervene, during these meetings, on issues related to Global Health Governance.

Activities include Watching the EB meetings in January and the World Health Assembly in May. Activities for both include developing a detailed commentary covering items on the EB and WHA agendas; a preparatory workshop for 'watchers'; attending a civil society strategy meeting (organised by Geneva Global Health Hub) to discuss the approach of civil society organisations. The second phase involves 'watching' the EB meeting and the WHA as part of the delegation of Medicus Mundi

International, intervening in discussions and advocating to the delegates on issues of importance.

Watchers are recruited through communication circulated to country circles and through PHM communication and social media, and selected using defined criteria such as: experience in activism and prior work in the field of health, especially on global health issues. The Watchers are oriented prior to going to Geneva and in Geneva are supported by a number of resource people (in Geneva and elsewhere)

The 5-day preparatory workshop is conducted as training on Global Health and specifically Global Governance for Health; to help watchers to engage, discuss, critically analyse and prepare statements on various agenda points; as well as a training to facilitate specific interventions and advocacy work in the EB meeting and WHA respectively; policy briefs for advocacy on important topics are drafted and statements identified and developed. Daily reports prepared by the Watchers are made available on the PHM website.

A new website has been created (http://who-track.phmovement.org/.) as an accompaniment to the WHO Watch website (http://www.ghwatch.org), which allows users to follow the discussions at WHA and EB meetings; and is a

knowledge management system for the WHO Watch activities.

The PHM commentaries prepared before the EB meetings and the WHA's, are acknowledged as the only comprehensive overview of the entire agenda shared with CSO's, all delegates and WHO officials. The commentary is publicized through the PHM website and used extensively by country delegations – especially less resourced delegations from low income countries, a variety of CSOs, and even WHO officials. The WHO watch team interacts with delegates and discusses matters that are felt to be globally important for the Right to Health.

Detailed notes of interventions by delegates and other discussions were recorded by Watchers and shared via a google document and a skype channel (subscribed to by over 100 members from PHM and other CSOs), allowing interested people to follow the proceedings and make easy reference to the discussions when needed. Organisations that were part of the skype channel and collaborated with the PHM in various ways included: Third world Network, Medicus Mundi International, Medico International, Health Action International, Knowledge Ecology Initiative, Universities Allied for Essential Medicines, Public Services International, MSF, International Baby Food Action Network (IBFAN) and Oxfam.

International People's Health Universities 2012 - 2018:

The International People's Health University (IPHU) is PHM's main educational and capacity development course. In addition to providing young activists with content information around issues such as globalisation and trade agreements, health systems, social determinants of health, etc., the IPHU also provides training in analysis and advocacy.

From mid-2012 (PHA3) until mid-2018, a total of 26 International People's Health University (IPHU) have been organized. In South Africa, two groups of participants, all Community Health Workers, had follow-up modules to their initial course – where specific projects initially identified were followed up, and later new modules were taught and listed as a separate course. In addition,the usual 2-week short courses / IPHU on the political economy of health have been held and organised by the local country circle or regionally in South Africa, El Salvador, London, USA and the Philippines. In addition to it becoming easier to source funding for national rather than global activities, the benefit of the in-country IPHU is being able to work with known activists and achieve improved follow up with participants; content can be specific to the country or participants' needs; and they can be structured over a period of time with follow up sessions, as has been done in South Africa, where a non-residential SAPHU was run over 5 weeks for 24 Community Care Workers, and since 2016, followed by project implementation. This modification followed the SAPHU evaluation - conducted as part of the Civil Society Engagement for Health for all project - which recommended piloting of SAPHUs with follow up modules.

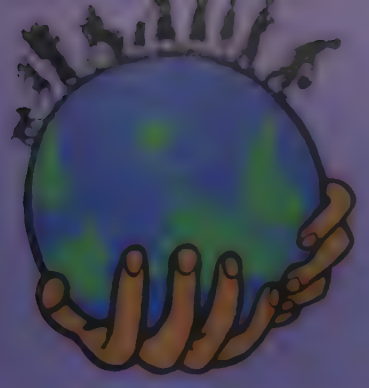
A number of "specialised" IPHUs have also been organized,for example on Intellectual Property and Access to Medicines, Public Information and Advocacy skills training.

A list of all IPHUs that have taken place

Place	Date
1. Cape Town, South Africa	July 2012
2. Manila, Philippines	October 2012
3. El Salvador	Nov 2012
4. LA, USA	July 2013
5. El Salvador	2013
6. Thessaloniki, Greece	November 2013
7. Online IPHU / IPOL	2013
8. South African People's Health University (SAPHU)	December 2013
9. South African People's Health University (SAPHU)	December 2014
10. IPOL – Global Health Governance (pre-WHA)	2014
11. El Salvador	2015
12. IP and Access to medicines, Delhi,	2015
13. WSF Tunis (IPOL and series of workshops during WSF)	2015
14. Brussels	April 2016
15. Seattle USA	April 2016
16. London UK,	June 2016
17. El Salvador	April 2016
18. El Salvador	November 2016
19. [1]South African People's Health University (SAPHU) module 1 and Module 2	June and December
20. Kathmandu, Nepal	November, 2016
21. South African People's Health University (SAPHU) – Leadership and conflict management follow up of participants who started June 2016	June and July
22. Philippines – Public Information and Advocacy skills training	2017
23. South African People's Health University (SAPHU) – non-residential SAPHU with community care workers from Western Cape modules 1 and 2	August – September 2017 June 2018
24. South African People's Health University (SAPHU) – Northern Cape Module 1 and 2	October 2017 and July 2018
25. South African People's Health University (SAPHU) - Sexual and Reproductive Health and Rights as a SDH Further module with participants who started June 2016	October 2018
26. Amman, Jordan	2018
27. Gender and Health, Savar, Bangladesh	6-13 November 2018
28. Access to Medicines, Savar, Bangladesh	6-13 November 2018[2]

[1] PHM South Africa People's Health University (SAPHU) changed in 2016: the initial core module is 5 days. After 6 -8 months there is a follow up module where groups report back on the projects they planned during initial SAPHU. For example, instead of just treating TB and giving health education, they work with the community to identify the and analyse the social determinants of health for TB and work with the community and other stakeholders to identify and address the deeper causes of TB. Additional new modules are also done with participants e.g. those on SRHR and leadership etc.

[2]The 2 short courses being run in advance of PHA4 (listed as 27 and 28), will have some joint sessions (for example on health activism, social determinants of health, comprehensive primary health care, the political economy of health), and will also split into two parallel streams of specialist study, dealing with medicines policy, and gender and health respectively.



Health for all campaign, mapping and political organising

At recent SC meetings there has been acknowledgement of the need to strengthen PHM's political organizing. In addition, many activities falling under the health for all campaign, have been taking place at the country level, but we were finding it difficult to have sustained coordination of these local campaigns at the global level.

In 2017 and 2018, PHM Europe has been coordinating a campaign around the April 7 World Health Day (renamed PEOPLE's health day) under the theme of "no to the commodification of health!". PHM circles and organizations were encouraged to share information about activities and to hang white sheets on the windows of institutions, hospitals, medical homes or offices of associations and visible in the streets and on the squares. In addition to the activities in Europe, organized actions took place several cities around the world, and recorded on an online map.

During PHA3, a number of themes appeared to be of concern and interest to many regions, and at the Steering Council meeting following PHA3 it was agreed to prioritise 5 of these thematic areas for global action: Nutrition and Food Security, Extractive Industries, Trade and Health, Gender and Health, Health Systems and Privatisation. The intention was to use such themes to strengthen PHM's own profile, focus and activity at country and global levels, to enrol the participation and strengthen otherPICSOs campaigning in these areas. While activity on these themes has often been sporadic, PHM has sometimes taken the lead in initiating national activity around some of them. Examples have been: a well-attended Nutrition and Food Systems conference in India which drew young activists into activity in this area; regional meetings on Trade and Health in Australia and the Pacific; and an IPHU is planned on Gender and Health.

At the SC meeting in January 2017, it was agreed to strengthen our political organizing around these themes. A comrade from South Africa was approached and asked to explore:

1) Re-invigorating the Health for all campaign by supporting and animating campaigns on various thematic issues and assisting in coordinating these local activities as global campaigns
2) Strengthening PHM's work in political organizing, especially of communications
3) In 2018 it was agreed that this activity would also would support the thematic campaigns development and mobilisation in the lead up to PHA4

Some work has been done on mapping what has taken place since 2013; and core thematic groups have been activated in the lead-up to PHA4. At PHA4 thematic workshops will be held to review progress on these themes and possibly modify our strategy to enhance the effectiveness of this initiative

In addition to the thematic work, PHM engages with relevant global initiatives as required. A recent example is our engagement around the Astana Primary Health Care Declaration and conference, on the 40th anniversary of Alma Ata. PHM was represented on the International Advisory Group, and facilitated input and responses into the 1st and 2nd drafts of the official declaration, and also coordinated the development of an alternative civil society statement which was endorsed by a large number of organisations (over 150) and individuals (over 250). A link to the statement is available on the website front page www.phmovement.org.

Movement building: participatory action-research and a new tool for activists

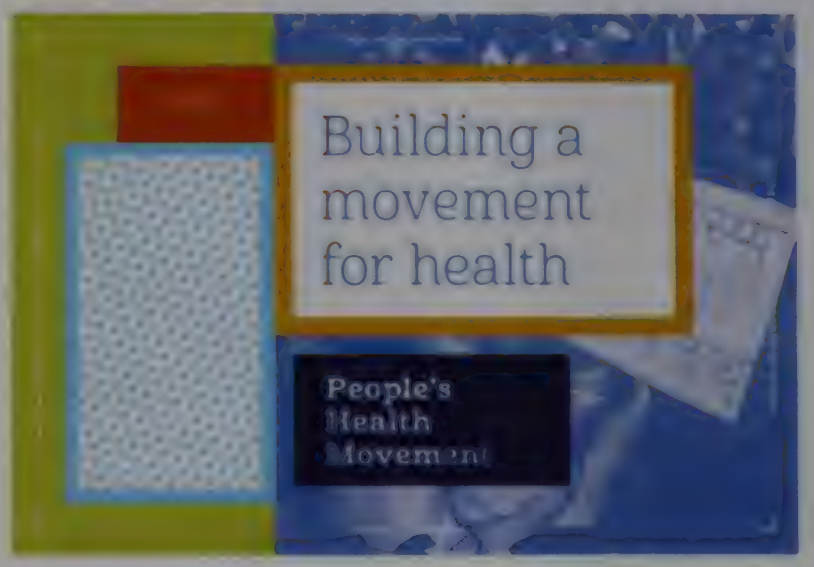
Between 2014 and 2018 PHM undertook, with the financial support of the Canadian International Development Research Centre (IDRC), a large multi-centre study exploring the engagement of civil society in the struggle for health for all ("The Engagement of Civil Society Organisations in Achieving Health for All" - CSE4HFA). Around 130 researchers from 10 countries participated in the research, which involved case studies of activism in six countries (Brazil, Colombia, DR Congo, India, Italy, and South Africa), evaluations of three of PHM's global programs, a review of activist narratives, a literature review of social movements in health, and a historical review of the health for all movement.

The research teams undertaking these different projects - formed by active members of PHM at the local, regional and/or global level - included a combination of senior activist/researchers and younger activist/researchers who were mentored by the former during the course of the project.

The project has been managed at the global level in consultation with the global Steering Council of PHM, and at the national level by PHM county circles. Country teams were supported through mentoring while acknowledging their autonomy in adapting the research design to the local context. As well as local discussions within the project teams there were six regional workshops and one global workshop where the findings of the different projects were presented and discussed.

The project as a whole was designed around the participatory action research cycle. During the first phase the various project groups (country and global) were asked to document and reflect upon actions and programs seen as part of the health for all movement in their country or globally. At the end of Phase 1 the country and global teams came together to reflect on findings and identify new ways of working (or even new projects). During Phase 2 the country and global project teams implemented these new directions and documented their strategies and outcomes. Thus, at the conclusion of the whole project there was scope for reflecting on and learning from the experience of implementing those new directions.

A final report of the project has been written, and will be made available together with the sub-reports from the different studies on the PHM website. Several publications from the project are also on the way.



In parallel with the action-research project, PHM together with the Belgian NGO Viva Salud developed two tools aimed at supporting activists and strengthening the movement: a multi-lingual interactive manual and a new section of the PHM website dedicated to movement building.

In 2016, PHM issued a call translated into different languages: 25 case studies were selected from those received, covering most world regions. A group of PHM volunteers from different countries worked together to

look at the stories, identify the practices, or key elements, of movement building (how the different groups got organised to lead action), and describe them in what later became the chapters of a book titled "Building a movement for health". The book is freely available for download from the PHM website in English, French, and Spanish, and has been extensively used in trainings and to support the work of local activists.

From the book, a new section of the PHM website has been recently developed, dedicated to movement building. In this area, it is possible to browse through six key practices of movement building (relationships and values, organisation and strategy, visible actions, participation, networking, learning from experience); access more than 25 case studies of health activism from all over the world; and to contribute one's experience by submitting a case study. This interactive material is intended to be an aid in the struggle for health equity, to support movement-building at the country level, and to contribute to the strengthening of PHM worldwide.

Challenges

Although there has been the emergence of new country circles, especially in Europe and West Africa, and the strengthening of some already existing country circles, it remains the case that global programmes command most of the resources and the majority of the time of PHM small secretariat. The challenge of mobilizing concerted activity around a radical agenda is daunting, particularly in countries which have a weak tradition of public interest civil society activity that is independent of external funding.

While the need for a strong, progressive and broad-based movement in health has never been greater, PHM still faces the challenge of translating its growing profile into a large, coherent, organised and sustainable movement with an expanding and decentralized leadership strongly rooted in mass organisations and at the same time connected to those also involved in similar activist work. The major global activities (IPHU, WHO Watch, Global Health Watch), PHM's public face in policy fora and meetings, as well as its ability to raise funds to support secretariat and activities, remain excessively reliant on a small number of longstanding activists.

While the demand for a people's health movement has increased, PHM's core funding has decreased as a result of (a) the external financial climate; (b) reductions in and changes to donor funding, with more specifically tied funding; and (c) the nature of PHM work which limits the range of donors who are willing to fund the movement and/or from whom PHM is willing to accept funds. It has been necessary to turn to more innovative ways to raise funds, including:

- Undertaking a large research project (CSE4HFA).
- Appealing for individual donations on a regular basis (initially there were once off donations from a few people in Australia; and we have very few ongoing donations from individuals in South Africa and Canada).
- Organizing a "consortium meeting" of like-minded organisations in Frankfurt (2015), with the support of Medico International. Primarily European organisations that supported the need for a health movement, were asked to consider contributing untied funds towards PHM on an annual basis. Some organisations committed to funding untied solidarity contributions on a regular basis; some have continued contributing annually which has been

a huge help in keeping the depleted secretariat going.

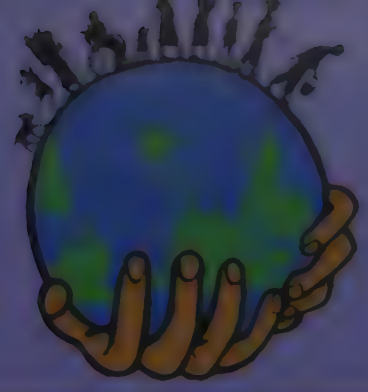
PHM has been or is currently in contact with many like-minded global and local organisations, popular movements and networks as well as many leading health thinkers and activists. These contribute resources and time to several of PHM programmes and initiatives, including attending PHM various Assemblies, writing for Global Health Watch without personal credit, participating actively in IPHUs and the WHO Watch programme and contributing to PHM interventions in various fora and meetings. Often however, this involvement is erratic and not sustained, partly to PHM limited capacity to nurture and follow up contacts, and partly because of people's own commitments.

PHM has over the past few years been undergoing a transition of its governance structures (regional coordination and global steering council) to facilitate improved communication, relevance, representation and accountability. Despite this, we are conscious that there are many supporters, activists, organisations, networks and social movements at both national and global level that could play a greater role in strengthening the movement and its capacity and impact, and acknowledge we need additional mechanisms to facilitate this. After some discussions, a call for Expression of Interest in hosting the global secretariat has been circulated, but no proposals were received until now. The global secretariat has been hosted by PHM South Africa since 2009. The structure has however changed with the Delhi secretariat coordinating a number of programmes. The secretariat has reduced in size since PHA3, but the workload has grown. Weneed to continue exploring strategies to move the global secretariat from South Africa in the coming years.

Since PHA3 there has been significant discussion in the Steering Council about PHM becoming a membership organisation. We have not reached consensus on this, with arguments presented both in support of and against this. After some discussions both in the lead up and at the Steering Council meeting in January 2017, some progress was made: benefits of membership were highlighted in a paper circulated for discussion and included: a way to formally engage individuals and organisations working with us on specific activities and in global programmes; catalysing progression to a more democratic member-led organization, as well as potentially raising funds for PHM's running costs. At the SC meeting, there was agreement to organizational membership, but with the provision that this be termed affiliation (rather than membership); that we could include national organisations as part of the affiliated organisations (previously limited to global and regional organisations and social movements) but only with oversight from the country circle (if there was one) or regional structures; contributions would be separate to affiliation; to be reviewed in 2019. A number of organisations were approached, with only a limited number affiliating and only a few of these agreeing to contribute financially. There were, however,only a limited number of national organisations approached, largely due to very few suggestions coming from regions, or inadequate information received.

In the discussions at the Steering Council meeting, there was no consensus reached about individual membership, with the biggest argument being that membership would require some sort of a fee, and is likely to exclude some people.

To keep PHM going, we have also significantly reduced the size and expenditure on the global secretariat: the Cairo secretariat was closed mid-2015 and remaining secretariat salaries (Cape



Town and Delhi) were reduced by 50%. Thus, our secretariat remains quite depleted through lack of funds, but staff continue to work, primarily driven by commitment to PHM and the belief that there is the need for a people's movement such as PHM. However, this situation is fragile unless we manage to secure more regular and sustained funding.

When PHM was initiated, it had a unified vision and belief in "health for all" – 18 years later and that vision has not been achieved: inequalities between and within countries persist; there's a push by some for a "limited package of services"; dismantling of public health systems and an increase in the role of the private sector, sometimes seen in the implementation of UHC; increased extractivism and environmental degradation; the list can go on. We believe that the need for ongoing joint collaboration and action by progressive, like-minded organizations and activists in building a stronger and more sustainable people's health movement is as needed now as it was in 2000.

Chiara Bodini (PHM Steering Council co-chair), David Sanders (PHM Steering Council co-chair), Bridget Lloyd (PHM Global coordinator).

Alternative Civil Society Astana Statement on Primary Health Care

We, members of public interest civil society organisations and social movements, some of whom are participants at the Global Conference on Primary Health Care, re-affirm our commitment to primary health care (PHC) in pursuit of health and well-being for all, aiming to achieve equity in health outcomes. We envision:

Societies and environments that prioritize, protect and promote people's health;
Health care that is accessible, affordable and acceptable for everyone, everywhere;
Health care of good quality that treats people with respect and dignity;
Health systems over which communities are able to exert control

Although these objectives are shared in the official Astana Declaration it is concerning that the latter frames PHC primarily as a "cornerstone", i.e. a foundation of Universal Health Coverage (UHC). PHC, is broader and indeed subsumes UHC, which is, in many countries, being implemented by private health insurance companies and aggravating health inequities. While the official declaration recognises that it is"ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist" it does not acknowledge that health gains in some places are being reversed. The declaration also recognises the risk factors for NCD's as well as premature deaths "because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors", yet nowhere are the fundamental economic and political causes responsible for this as well as for widening inequalities worldwide explicitly stated. These are some of the reasons why the People's Health Movement and other progressive public interest civil society organisations and social movementsfeel it necessary to elaborate an Alternative Statement.

Attaining the highest possible standard of health is a fundamental right of every human being, as stated in the Constitution of the World Health Organization. Forty years ago, in 1978, world leaders made the historical commitment to achieve health for all through Primary Health Care in the Declaration of Alma-Ata. We, the undersigned, express the need for urgent action by all international agencies and governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, and hereby make the following Statement:

1. We the undersigned strongly reaffirm that health, which is a state of complete physical, mental, social, cultural, and ecological wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization is the responsibility of governments and

requires the action of many other social and economic sectors in addition to the health sector. People's health depends on working and living conditions that promote flourishing lives and a healthy and protected natural environment.

2. The existing extreme and growing inequality in the economic and health status of the people both across the world, as well as between and within countries, is politically, socially, economically and ethically unacceptable and a source of conflict and environmental destruction and is, therefore, of common concern to all countries.

3. Equitable economic and social development will require rejection of the currently dominant neo-liberal paradigm and establishment of a sustainable and equitable economic order globally and nationally. Amongst other interventions regulation of financial flows and of tax havens and evasion are urgently needed. These changes, along with recognition and action to address inequities due to gender, caste, race, disability and sexual orientation, are of basic importance to the fullest attainment of health for all and to the reduction of the gap in the health status within and between countries. The promotion and protection of the health and wellbeing of all people will enable sustainable and equitable forms of social and economic development that will contribute to world peace and environmental protection.

4. People should be afforded every opportunity to participate individually and collectively in the planning and implementation of their health care. This participation should respect age, gender, ethnicity and socio-economic status and use digital technologies where appropriate.

5. Governments have a responsibility to realise the right to health of their people along with other rights specified in the United Nations (UN) Declaration of Human Rights. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world of a level of health that will permit them to lead socially and economically flourishing lives. The United Nations SDGs could be important in reaching this target if they are underpinned by the establishment of a global and national equitable and sustainable economic order. Primary health care is the key to attaining Health for All as part of development in the spirit of social justice, and which is eminently possible given current knowledge, technology and resources.

6. Effective and accountable global governance for health is required to realise PHC. This should include means of effective taxation to ensure that all individuals and corporations pay their fair share of taxes to enable the funding of health and other services beneficial to health;

7. By 2018 the survival of life on earth is threatened by accelerating climate change. Thus part of the PHC approach should be to endorse the Earth Charter (2000) which proposed we are all citizens of our planet as well as our nation states. It recognised the interconnections between living in harmony with and protecting the natural environment and other species, and living in peace, with equity and social justice within human societies; all core parallel principles shared with the Primary Health Care movement.

8. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology

made universally accessible to individuals and families in the community through their full participation in the spirit of self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It gives particular emphasis to the household and community levels and the first level of care, bringing comprehensive health care as close as possible to where people live and work, and is fully integrated with other levels of care.

9. Primary health care:

   I. reflects and evolves from the economic conditions and sociocultural and political characteristics of a country and its communities and is based on the application of relevant social, biomedical and health systems research and public health experience;

   II. addresses the main health problems in the community, providing promotive, preventive, curative, rehabilitative and palliative services accordingly;

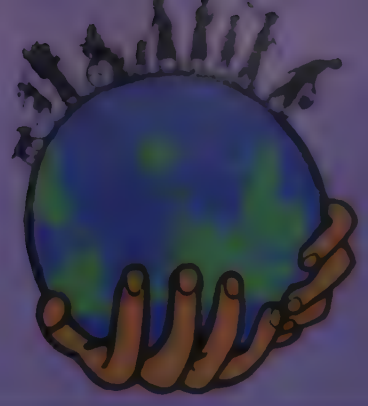
   III. includes at least: health education concerning prevailing health problems and the methods of preventing and controlling them; promotion of a healthy food supply and proper nutrition; an adequate supply of safe water and basic sanitation; reproductive and sexual health care, including maternal health care, contraception, abortion; prevention and health care for gender based violence; child health care; immunization against the major infectious diseases; prevention and control of locally endemic diseases and non-communicable disease including mental health illness; appropriate treatment of common diseases and injuries; providing for the healthcare needs of the disabled; and provision of essential drugs;

   IV. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, trade, food, industry, education, housing, public infrastructure, communications and information technology and other sectors; and demands the coordinated efforts of all those sectors;

   V. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops, through appropriate training, the ability of communities to participate;

   VI. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

   VII. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, mid-level workers and community health workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community. All governments should formulate national policies, strategies and plans of action to strengthen and sustain primary health care as part of a comprehensive national health system and in coordination with



other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

10. While technology has brought health benefits, care must be taken to ensure that technology is used with intelligence so that:

    I. New bio-technology and artificial intelligence should be assessed in terms of its potential to do harm as well as good and in terms of its contribution to overall population health and equity and be regulated as necessary

    II. Over-servicing, especially in the private sector, requires regulation. One aspect of this which is contributing to the crisis of anti-microbial resistance is irrational and overuse of antibiotics in both the health and industrial farming sectors

    III. The use of digital technologies has the potential to increase access and quality of care but strategies must be informed by an awareness of the digital gradient, which mirrors socio-economic inequities. Special measures need to be taken to flatten this gradient.

11. An essential component of primary health care is universal health coverage which should be universalist, based on social solidarity and built on a unified public funded system, with most service provision through public institutions.

12. Since the protection and attainment of health by people in any one country directly concerns and benefits every other country, development assistance, including donor programs, must be accountable to and strengthen national public health systems and address the social, environmental and ecological determinants of health.

13. The training of health personnel requires to be more strongly oriented to primary health care and employment conditions need to ensure fair and safe working situations. Distribution of health personnel is grossly inequitable and reflects the inverse care law. Global and national policies should institute policies to mitigate the brain drain from low and middle income countries to high income countries by inter alia increasing production of their own health workers and compensating sending countries for their losses in training costs.

14. Health gains from the implementation of an effective primary health care system can be easily undermined by the commercial determinants of health, including promotion and trade of health harming commodities (e.g. ultra processed food, alcohol, tobacco) and environmentally damaging extractive industries. Global and national policies, including effective regulation, are needed to prevent their adverse impacts.

15. An acceptable level of health for all the people of the world can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

We the undersigned, representing a wide range of public civil society organisations and social movement call on the Global Conference on Primary Health Care to undertake urgent

and effective national and global action to develop and implement primary health care throughout the world and particularly in low and middle income countries in a spirit of technical cooperation and in keeping with a sustainable and equitable economic order. It urges governments, WHO, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in low and middle income countries. We call on all the aforementioned to collaborate in strengthening, developing, funding and maintaining public health systems based on primary health care in accordance with the spirit and content of this Statement.

As of November 7th 2018, 174 organisations from 48 countries; and 326 activists, community workers, trade unionists, academics, health professionals and others from 43 countries have endorsed the statement.

Please consider endorsing this through the PHM website www.phmovement.org.

15 November, 2018